Code Requests Made by the National HIPAA EOB Sub-Group(A Subsidiary of the National Medicaid HIPAA Workgroup)

The National HIPAA Explanation of Benefits (EOB) Sub-Group, which is a subsidiary of the National Medicaid HIPAA Workgroup, began meeting via conference calls in March 2000. The EOB group was chaired by Diane Davidson of Kansas Medicaid (dzzd@srskansas.org). The group=s purpose was to review state EOB messages against the related Transaction 835 messages and identify where changes or additions were needed in order to meet state needs. The group concentrated on crossing state EOB messages to two external code lists that are used in the 835 Remittance Advice Transaction. These two external code lists are:

- **Claim Adjustment Reason Codes: These are maintained by the ANSI ASC X12N Health Care Code Maintenance Committee.**
- **Remittance Advice Remark Codes: (formerly called Medicare Remark Codes): These are maintained by HCFA.**

States were asked to make a first attempt to match their own EOB messages to the national codes and then submit only those that they had trouble matching to the subgroup for further review. A subset of the group then met in Kansas in May 2000 and reviewed over 700 EOB messages that were submitted by nine states. The group reviewed each of the submitted 700 codes/messages with two exceptions:

- **Dental Codes Specific to California: California will conduct their own analysis.**
- **Codes Regarding Claim Reversals and Corrections (Commonly Referred to as "Adjustments" in the Medicaid World): The group determined that the needs represented by most of the submitted adjustment-related codes could be accommodated through a better understanding of the Transaction 835 Reversals and Corrections process. Arrangements were made for training on this topic. The training was provided to the National Medicaid HIPAA Workgroup in July 2000.**

As a result of the above exercise, 28 new or modified Remark Codes and 10 new or modified Claim Adjustment Reason Codes were requested. These requests, along with the responses received, are listed in the attached ACode Requests Made by the National HIPAA EOB Sub-Group@ Paper. Through this effort some changes were made that will be applicable to states across the nation. States who, after further reviewing their own EOBs, find that they need additional code changes can make their requests directly as follows:

- **Claim Adjustment Reason Codes: Make requests through the Washington Publishing website (wpc-edi.com). Select HIPAA, then Code Lists and Claim Adjustment Reason Codes. Then choose the List Maintenance function.**
- **Remittance Advice Remark Codes: Make requests through the Washington Publishing website (wpc-edi.com). Select HIPAA, then Code Lists and Remittance Advice Remark Codes. The instructions for requesting changes are at the end of the code list. Requests may also be sent directly to Kathleen Simmons at HCFA (ksimmons@hcfa.gov).**

<u>Lessons Learned and Pertinent Information for EOB Mapping:</u>

- The national Claim Adjustment Reason and Remittance Advice Remark messages were not intended to be used to explain state medical program requirements or medical benefit coverage. Instead, these national codes are intended to explain why the payer is paying a different amount than was billed by the provider.

- It is important to understand how the 835 Remittance Advice Transaction is designed to work before requesting additional or modified codes. In the 835, each change from the billed amount is listed as a separate Aadjustment@ on the remittance advice. In many cases, an EOB message that is currently used may no longer be needed under the 835 format.

- Messages should be kept as short as possible.

- It is recommended that states use the same messages on both electronic and paper remittance advices.

- States should evaluate current EOB usage and get rid of the ones not in current use prior to beginning the mapping process.

- Medicare found that phone calls went up temporarily when they converted to the national codes but this seemed to even out over time.

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Remittance Advice Remark Codes:

The following two tables document the requests made for new and modified Remittance Advice Remark Codes (formerly called Medicare Remark Codes) as a result of the EOB Sub-Group=s work.

Requests for New Remark Codes:

Requested Additional Remarks Codes	New Message Approved By HCFA	Comments/ Additional Information
AA **B** Payment based on authorized amount.	N45 - Payment based on authorized amount.	N/A
AH **B** Incomplete/invalid admission hour.	N46 **B** Missing/incomplete invalid/ admission hour.	N/A
CC **B** Claim conflicts with another inpatient stay.	N47 **B** Claim conflicts with another inpatient stay.	N/A
CI **B**Claim information does not agree with information received from other insurance carrier.	N48 **B**Claim information does not agree with information received from other insurance carrier.	N/A
CO **B** Court ordered coverage information needs validation.	N49 **B** Court ordered coverage information needs validation.	N/A
DI **B** Discharge information incorrect/invalid.	N50 **B** Discharge information missing/incomplete/ incorrect/invalid.	N/A
EC **B** Electronic agreement not on file for provider/submitter.	N51**B** Electronic agreement interchange not on file for provider/submitter.	N/A
MC **B** The patient is not enrolled in the billing provider=s managed care plan on date of service.	N52 - Patient not enrolled in the billing provider=s managed care plan on the date of service.	N/A

MP **B** Records indicate that patient has Medicare or other insurance.	Request Not Approved	This replicates information in reason code 22 (Claim adjusted because this care may be covered by another payer per coordination of benefits), and in the "Corrected Priority Payer Name" NM1 segment of the 835 version 4010. As noted in that NM1 segment, "This segment is required when the current payer believes that another payer has priority for making a payment. Use of this segment identifies the priority payer." A zero payment amount would be shown for services denied with reason code 22.
PA **B** Claim Information is inconsistent with pre-certified/authorized services.	N54 - Claim information is inconsistent with pre-certified/authorized services.	N/A

PB **B** Procedures for billing with group/referring/performing providers were not followed.	N55 - Procedures for billing with group/referring/performing providers were not followed.	N/A
PC **B** Procedure code billed is not correct for the service billed.	N56 - Procedure code billed is not correct for the service billed.	N/A
PD - Incomplete/invalid/missing prescribing and/or dispensed date.	N57 - Missing/incomplete/invalid prescribing/dispensed date.	N/A
PL **B** Patient Liability amount missing, invalid or not on file.	N58 - Patient liability amount missing, invalid, or not on file.	N/A
PM **B** Please refer to your provider manual for additional program and provider information.	N59 - Please refer to your provider manual for additional program and provider information.	N/A
PR **B** Procedure code or procedure rate count not be determined or was not on file for date of service/provider. Please contact Health Plan prior to refilling the claim.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. Please contact the Health Plan prior to re-filing the claim.	N/A

RR **B** This recipient is restricted to specific providers.	Request Not Approved	This information is contained in reason code 38, [Services not provided or authorized by designated (network) providers.]
SB **B** Re-bill services on separate claims.	N61 **B** Re-bill services on separate claims.	N/A

SC **B** An inpatient admission spans multiple rate periods. Resubmit separate claim.	N62 - Inpatient admission spans multiple rate periods. Resubmit separate claims.	N/A
SS **B** Re-bill services on separate claim lines.	N63 **B** Re-bill services on separate claim lines.	N/A
TP **B** Please submit hard copy claim and/or required attachment.	Request Not Approved	Under HIPAA, a payer will not be able to require that any provider submit a hard copy claim when that provider is able to submit a compliant HIPAA format claim.
WA - Claim did not meet waiting period requirements.	Request Not Approved	This information is contained in reason code 30, **A**Claim/services are adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements**@**.

Requests for Modifications to Remark Codes:

Requested Modifications to Remark Codes: **[Requested modifications are identified via underlines for additions and strikeouts (~~strikeouts~~) for deletions.]**	**Modified Message Approved By HCFA**	**Comments/Additional Information**
M29 Claim lacks the operative report, medical records or necessary documentation.	Request Not Approved	The changes were not made to M29. Use Code M67: "Incomplete/invalid other procedure code(s) and/or date(s).
M51 add to end or the description is insufficient.	M51 - Incomplete/invalid, procedure code(s) and/or rates, including not otherwise classified or unlisted procedure codes submitted without a narrative description or the description is insufficient.	N/A

MA06 **B** Incorrect/incomplete/missing beginning and /or end date(s) on claim.	MA06 - Incorrect/incomplete/missing beginning and/or ending date(s) on claim.	N/A
MA66 **B** Incomplete/Invalid principal/other procedure code and/or date.	Request Not Approved	The changes were not made to MA 66 . Use Code M67: "Incomplete/invalid other procedure code(s) and/or date(s).
N3 **B** Required/consent form not on file, incorrect or incomplete.	N3 - Required/consent form incomplete, incorrect, or not on file.	N/A
N10 Claim/Services adjusted because of the finding of review organization/professional consult/manual adjudication.	N10 - Claim/service adjusted because of the finding of a Review Organization/professional consult/manual adjudication.	N/A

Claim Adjustment Reason Codes:

The following three tables document the requests made, as a result of the EOB Sub-Group=s work, for: new, modified and reactivated Claim Adjustment Reason Codes.

Request for New Claim Adjusted Reason Code:

New Code Requested via Website	Message Approved By ANSI ASC X12N Health Care Code Maintenance Committee	Additional Explanations and Responses Posted on the Website Conference Board_
PCP - Provider not assigned as patients primary care physician on date of service._	Request Not Approved___	Request withdrawn by Medicaid Representative at June 2000 Code Committee meeting based on consensus of Committee members._____

Requests for Modifications to Claim Adjustment Reason Codes:

Modifications Requested via Website Form [Requested modifications are identified via underlines for additions and strikeouts (~~strikeouts~~) for deletions.]____	Modified Message Approved By ANSI ASC X12N Health Care Code Maintenance Committee	Additional Explanations and Responses Posted on the Website Conference Board_
6 - The procedure/revenue code is inconsistent with the patient=s age.	Request Not Approved_____	Request withdrawn: Revenue code is considered a procedure code in the transaction 835.____
15 **B** Claim/Service denied because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider._____	15 **B** Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	N/A

30 **B** Benefits are reduced or not available for these serviced until the patient has the required eligibility, patient liability, spenddown, waiting, or residency requirements.	30 **B** Claim/Service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	N/A
31 **B** Claim denied as patient cannot be identified or is not eligible as our insured.	Request Not Approved	Request withdrawn by Medicaid Representative at June 2000 Code Committee meeting based on consensus of Committee members.
47 **B** This (these)diagnosis(es) is (are)not covered, missing or are invalid.	47 **B** This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	N/A
61 **B** Charges/services reduced/denied for failure to obtain second surgical opinion.	61 **B** Charges adjusted as penalty for failure to obtain second surgical opinion.	N/A

141 **B** Claim denied/reduced because the claim spans eligible and/or ineligible periods of coverage.	141 **B** Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N/A
B6 **B** This service/procedure/claim type is denied/reduced when performed/billed by this type of provider, by this type of provider in this facility, or by a provider of this specialty.	Request Not Approved	Request withdrawn by Medicaid Representative at June 2000 Code Committee meeting based on consensus of Committee members.

Request to Reactivate Claim Adjustment Reason Code:

Requested via Website Form	**Message Approved By ANSI ASC X12N Health Care Code Maintenance Committee**	**Additional Explanations and Responses Posted on the Website Conference Board**
Reactivate the following: 63 - Correction to a prior claim.	Request Not Approved	Withdrew this request because it has to do with the reversals and corrections process. We found we didn=t need this after receiving additional training on those processes.